OptimaHealth
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

Enrollment Application

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse, or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Continuation Of Coverage For Children With A Disability:

Children over age 26 with a mental or physical disability will continue to be eligible for coverage. You will need to include a written statement from the child's physician with this application. Call member services for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.

Notice of Special Enrollment Opportunity for Children under Age 26.

Children under age 26 whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in your Optima Health group plan. You may request enrollment for such children for 30 days from your group effective date. Enrollment will be effective on the first day of your Optima Health group coverage. For more information contact Optima Health member services.

Notice of Lifetime Limits and Opportunity to Enroll

Lifetime limits on the dollar value of benefits under Optima Health no longer apply. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan will have an opportunity to enroll in the Plan. Individuals have 30 days from your group effective date to request enrollment. For individuals who enroll under this opportunity, coverage will take effect not later than the first day of the Plan coverage effective date. For more information contact Optima Health member services.

OptimaHealth

Clear Form

Sentara Health Plans, Inc
4417 Corporation Lane Virginia
Beach, VA 23462
(757) 552-7401 (877) 552-7401

Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: _____ Soc. Sec. #: _____

Date of Birth: ____

NOTE: Complete section 1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Employer: _____

Group Number: _____

Policyholder's Name: _____

Birthdate: _____

List family members covered by this insurance:

_____

SECTION 2 (Medicare Information)

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

Spouse: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group insurance or service plan.

Signature of Applicant:	**Date:**

OptimaHealth

www.optimahealth.com

FOR PLAN USE ONLY

Subscriber #: _____

Date: _____

Enrollment Application

☐ **Vantage**

☐ **Plus**

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 4 To be completed by employer Group No._____ (For Office Use Only) Sub Group No. _____ (For Office Use Only)

☐ **NEW** ☐ **Open Enrollment** ☐ **Continuation of Coverage** ☐ **C.O.B.R.A.** ☐ **PCP or Demographic Change**

☐ **Cancel All** ☐ **Add Dependent/Spouse** ☐ **Cancel Dependent/Spouse** ☐ **Reinstatement**

Employer Name: _____ **Effective/Expiration Date of Coverage:** _____ **Employee's Social Security No.** _____ **Hire Date:** _____

Section 5 TO BE COMPLETED BY EMPLOYEE- **(PLEASE PRINT LEGAL NAME)**

Last Name: _____ First Name: _____ Middle Init. _____

Address: _____ Primary Language: _____

City/State/Zip: _____

Primary Phone: ( ) _____ Secondary Phone: ( ) _____

Section 6 **Additional Coverage-**

REQUIRED INFORMATION TO BE COMPLETED BY EMPLOYEE FOR ALL PERSONS LISTED BELOW.

Will any of the persons listed below have any other medical health insurance in addition to this Group Health Plan, when this coverage takes effect? ☐ Yes ☐ No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached.

Section 7 **Communication-**

Please select the method in which you would prefer to receive communications from Optima Health.

	Print	**Electronic**	
EOBs: *Explanation of Benefits*	☐	☐	**Email Address:** ***(Required)***
SBC: *Summary of Benefits & Coverage*	☐	☐	_____
Other Communications: *Newsletters etc.*	☐	☐	_____

Section 8

Please list below all persons to be covered by the enrollment application. Choose a primary care physician (PCP) by consulting the online provider directory or you may call member services. You may choose a different primary care physician for each member of your family. You may choose a pediatrician as a PCP for children. Although referrals to see specialists are not required, we will need your choice of both a primary care physician and location in order to process this application.

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/ F	Primary Care Physician & ID #	Current Patient
	SELF			/ /		DR.	
	SPOUSE			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE) _____

Section 9

Authorization-

I am applying for coverage for myself and the family members listed, and agree that once enrolled I and my family members will abide by the provisions of coverage in the Group Health Plan Summary Plan Description. This Plan is administered but not underwritten by Sentara Health Plans, Inc which does business as Optima Health.

I understand that misrepresentation in answering questions on this application, or non-payment of premiums may result in loss of eligibility for coverage under the Group Health Plan.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to Optima Health medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. I also give Optima Health the right to receive from, and release information to, other insurance companies needed to administer coordination of benefits (COB) provisions under the Group Health Plan Summary Plan Description.

I understand that Optima Health upon receiving information may use it to evaluate eligibility for coverage, a claim for benefits, a request for change in policy benefits, or administer COB. This Authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record.

Any information received by Optima Health pursuant to this application is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand and agree that no benefits shall take effect until this application is received and processed by Optima Health and an Optima Health ID card with an effective date of coverage has been provided.

I understand that it is my responsibility to report and verify to the Group Health Plan Administrator any change in the eligibility of myself or my covered family members. If requested, I agree to supply acceptable documentation. I also understand that I am obligated to pay applicable copayments, coinsurance or deductibles at the time services are provided according to the terms and conditions.

I certify that I have maintained a copy of this completed application for my records. I further understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that, for the purpose of collecting information in connection with this application, this authorization is valid for 30 months from the date of my signature; and for the purpose of collecting information in connection with a claim for benefits this authorization is valid for the term of coverage of the policy.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

Clear Form Print Form

OptimaHealth

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Optima Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Optima Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

Peggy Baker, Civil Rights Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
757-552-8839, 757-552-7440 (Fax)
PABAKER@sentara.com

If you believe that Optima Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Donna Pillatsch, Director of Compliance and Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462
757-552-7485, 757-552-7116 (Fax)
DHPILLAT@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Donna Pillatsch (above) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Optima Health Alternative Language Options for Notices and other Written Information

English: This Notice has Important Information. This notice has important information about your application or coverage through Optima Health. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-687-6260.

Amharic:
ይህ ማስታወቂያ ጠቃሚ መረጃ አለው።። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም በ Optima Health **በኩል ስለሚኖርዎት ሽፋን ጠቃሚ መረጃ አለው።። በዚህ ማስታወቂያ ላይ ያሉትን ቁልፍ የሆኑ ቀናቶችን ያስተውሉ።። የጤና ሽፋንዎትን ለማስቀጠል ወይም ወጪዎትን ለማገዝ እንዲቻል በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ሊያስፈልግዎ ይችላል።። በራስዎ ቋንቋ ያለምንም ክፍያ ይህን መረጃም ሆነ ድጋፍ የማግኘት መብት አለዎት።። 1-855-687-6260 ይደውሉ።**

Arabic:

يحتوي هذا الإخطار على معلومات مهمة. يحتوي هذا الإخطار على معلومات مهمة تتعلق بطلبك أو ببرنامج التغطية الخاص بك لدى شركة التأمين الصحي Optima Health. ابحث عن التواريخ الرئيسية في هذا الإخطار، فقد تحتاج إلى اتخاذ أي إجراء قبل حلول المواعيد النهائية للحفاظ على برنامج التغطية الصحية أو الحصول على مساعدة في التكاليف. ولديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك بدون أي تكلفة. يُرجى الاتصال 1-855-687-6260

Bengali/Bangla:
এই বিজ্ঞপ্তিতে রত্বপূণ তথ রেয়েছ। এই প্রজ্ঞাপেন Optima Health (অিপ্টমা হেলথ)-এর মাধ মে দাখিল করা আপনার দরখাস্ত বা কভাের্জর উপর গরত্বপূণ তথ রেয়েছ। এই বিজ্ঞপ্তিতে উেল্লখ করা গরত্বপূণ তারিখগেলা দেখ নিন। আপনার হেলথ কভাের্জ বজায় রাখার জন বা খরেচর
বিষেয় সহায়তা লাভের জন আপনাকে নিিদ ষ্ট সময়সীমার মেধ ব বস্থা গ্রহণ করেত হেত পারে। বিনা খরেচ আপনার মাতৃভাষায় এই তথ এবং সহায়তা পাওয়ার অিধকার আপনার রেয়েছ। কল 1-855-687-6260.

Chinese (Mandarin):
该通知含有重要信息。本通知含有关于 Optima Health 申请或保险的重要信息。请仔细查看本通知中的关键日期。您需要在截止期之前采取相应的行动，从而保障您的保险继续有效，能够为您提供报销。您有权免费获取信息的中文版，并可以免费获取到相关的中文帮助。請撥電話 1-855-687-6260.

French: Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Optima Health. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-855-687-6260.

German: Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Optima Health. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-855-687-6260.

Hindi:
इस सूचना में महत वपूणर जानकारी िनिहत है। इस सूचना में Optima Health के माध यम से आपके आवेदन या कवरेज के बारे में महत वपूणर जानकारी िनिहत है। इस सूचना में िनिहत महत वपूणर ितिथयों को देखें। आपको लागत के साथ अपने स्वास्थ य का कवरेज रखने या सहायता के लिए िनिश्चत समय सीमा में काररवाई करने की
जरूरत हो सकती है। आपके पास बिना किसी लागत के अपनी भाषा में इस जानकारी और सहायता को प्राप्त करने का अधिकार है। कॉल 1-855-687-6260

Ibo: Ọkwa a nwere Ozi Dị Mkpa. Ọkwa a nwere ozi dị mkpa maka akwụkwọ anamachọihe ma ọ bụ mkpuchi gị sitere na Optima Health (Ahụike Optima). Chọọ ụbọchị ndị dị mkpa n'ọkwa a. Ị nwere ike ịme ihe tupu ụfọdụ ụbọchị iji dowe mkpuchi ahụike gị ma ọ bụ enyemaka n'ụgwọ. Ị nwere ike ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Kpọ 1-855-687-6260

Korean: 이 공지는 매우 중요한 정보입니다. 이 공지는 옵티마 핼스를 통한 귀하께 적용되는 지원이나 보험에 대한 매우 중요한 정보입니다. 이 공지의 주요 날짜를 찾아보십시오. 귀하께서는 귀하의 건강 보험이나 비용에 관한 도움에 관련된 특정 마감일을 지켜야만 합니다. 귀하께서는 따로 비용없이 귀하의 언어로 이 정보와 도움을 받을 권리가 있습니다. 로 전화하십시오 1-855-687-6260.

Kru/Bassa: Náùm pò wùdù nà kɛ kpà dɛ mìù. Ɔ mɔ dɛ kpà dɛ bá nì dyí kánà-kánà dyì dé Optima Health mú. Mɔ tì kpà dɛ bè nì dé náùm pò wùdùɔ mú. Mɔ tì kpà dɛ bè nì dé náùm pò wùdùɔ mú. M bè dé bɛ m ké náùm pò pòɔ ɔ mù pó dyì. Ɔ jù kè m dyì dɛ bɛà nyùɛn, m wídíɔ mù bì dì dyì. Wà bì dì bɛ wà kè náùm pó wùdù nà kɛ Bàsɔ wùdù mù pò. Sebel 1-855-687-6260.

Navajo: Díí saad íliinii baa hane'. Naaltsoos·ni'íníłtsoozígíí éí doodago kwe'é Optima Health nik'é'ésti'ígíí bína'ídíłkidgo díí kwe'é hazhó'ó baa ákonínízin dooleeł. Yoołkáał yę́ędą́ą́' nich'į' é'élyaago biká'ígíí hádídíí'įįł. Díí niké'ésti'ígíí éi doodago béeso da bee níká a'doowołígíí bikáa'go da át'ée dooleeł áko t'áadoo bee e'e'aahí baa yíłkaahgo tsx́íį́łgo hasht'e díílííł níi da dooleeł. Bee haz'áanii hóló díí kót'éego yaa halne'ígíí bee níká a'doowołgo dóó t'áá nizaadk'ehjí bee nił hodoonih t'áadoo bą́ą́h ílíní. 'Átah ánǫ́ t'í'ígíí bee baa 'áháyą́ągéé bich'į' bibéésh bee hane'í hwéédilní. 1-855-687-6260.

Persian/Farsi:
این اعلامیه حاوی اطلاعات مهمی است. این اعلامیه حاوی اطلاعات مهمی درباره درخواست شما و پوشش Optima Health است. به تاریخ های کلیدی عنوان شده در این اعلامیه دقت کنید. ممکن است لازم باشد تا یک تاریخ مقرر خاص اقدام کنید تا پوشش بیمه تان حفظ شود یا در رابطه با هزینه ها به شما کمک شود. شما از این حق برخوردار هستید تا این اطلاعات و هرگونه راهنمایی دیگر را به زبان خودتان و به صورت رایگان دریافت کنید. 1-855-687-6260

Russian: В данном уведомлении содержится важная информация. В данном уведомлении содержится важная информация о Вашей заявке или страховом покрытии в компании Optima Health. Обратите внимание на важные даты, указанные в данном уведомлении. Если Вы хотите продолжать пользоваться мед.страхованием или получить помощь с оплатой, возможно, Вам потребуется принять решение до определенной даты. У Вас есть право на бесплатное получение данной информации и помощи на родном языке. Звоните по телефону 1-855-687-6260.

Spanish: Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Optima Health. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-855-687-6260.

Tagalog: Ang Paunawang Ito ay Naglalaman ng Mahalagang Impormasyon. Ang paunawang ito ay naglalaman ng mahalagang impormasyon tungkol sa inyong aplikasyon o saklaw sa pamamagitan ng Optima Health. Hanapin ang mahahalagang petsa na nakasaad sa paunawang ito. Maaaring kailanganin ninyong gumawa ng hakbang bago sumapit ang ilang partikular na takdang petsa upang mapanatili ang inyong saklaw na pangkalusugan o tulong sa mga gastusin. Mayroon kayong karapatan na matanggap ang impormasyong ito at makakuha ng tulong sa inyong wika nang walang bayad. Tumawag sa 1-855-687-6260.

Urdu:
اس نوٹس میں اہم اطلاع موجود ہے۔ اس نوٹس میں آپ کی درخواست یا Optima Health کے ذریعے کوریج کے حوالے سے اہم اطلاع موجود ہے۔ اس نوٹس میں درج کلیدی تاریخوں کو ذہن میں رکھیں۔ آپ کے لیے ضروری ہے کہ مخصوص ڈیڈلائنوں سے قبل اس حوالے سے کوئی ایکشن لیں تاکہ آپ کی کوریج برائے صحت اور لاگت کے حوالے سے معاملات طے رہیں۔ آپ اس اطلاع تک رسائی اور بغیر کسی خرچ کے اپنی زبان میں اس بابت جاننے 1-855-687-6260

Vietnamese: Thông báo này có thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn đăng ký hoặc về bảo hiểm của quý vị thông qua Optima Health. Quý vị hãy xem những ngày quan trọng trong thông báo này. Quý vị có thể cần đưa ra hành động trước ngày hết hạn cụ thể để duy trì bảo hiểm sức khỏe của quý vị hoặc hỗ trợ thanh toán cho các chi phí. Quý vị có quyền nhận được thông tin và sự hỗ trợ này theo ngôn ngữ mà quý vị muốn mà không phải trả thêm chi phí nào. Xin gọi số 1-855-687-6260.

Yoruba: Àkíyèsí yìí ní Àlàyé Pàtàkì. Àkíyèsí yìí ní àlàyé pàtàkì nípa ohun tí o bèèrè fún tàbí gbígbà ìtójú nípasẹ̀ Optima Health. Wo àwọn ọjọ́ tó ṣe kókó nínú àkíyèsí yìí. O lè nílò láti gbé ìgbésẹ̀ nípa gbèdéke kan láti ṣètójú ìlera rẹ tàbí ṣèrànw ọ́ nípa iye òwó. O ní ẹ̀tọ́ láti gba àlàyé yìí àti ìrànwọ́ yìí ní èdè rẹ láìsan owó. Pè sórí 1-855-687-6260.